

# Correspondence

## Eosinophilic Meningitis

TO THE EDITOR: We read with interest the article by Fuller and colleagues, "Eosinophilic Meningitis Due to *Angiostrongylus cantonensis*."<sup>1</sup> In their useful discussion of causes of cerebrospinal fluid eosinophilia, the authors omitted fungal infections of the central nervous system, particularly coccidioidal meningitis, as a cause of eosinophilic meningitis. We recently reported 3 cases of eosinophilic meningitis caused by coccidioidal meningitis,<sup>2</sup> and in a retrospective review of 27 cases of coccidioidal meningitis at Kern Medical Center in the southern San Joaquin Valley in California, we found that 9 (30%) patients had eosinophilic meningitis according to Kuberski's criteria of more than  $10 \times 10^6$  per liter of eosinophils in the cerebrospinal fluid.<sup>3</sup> Accordingly, we concluded that meningitis caused by *Coccidioides immitis* is probably the most common cause of eosinophilic meningitis in endemic regions. As helminthic infections in general and *A cantonensis* specifically are unusual occurrences in the United States and are limited to rare cases among immigrants to this country, coccidioidal infection should also be considered.

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## REFERENCES

1. Fuller AJ, Munckhof W, Kiers L, Ebeling P, Richards MJ: Eosinophilic meningitis due to *Angiostrongylus cantonensis*. West J Med 1993; 159:78-80
2. Ismail Y, Arsura EL: Eosinophilic meningitis associated with coccidioidomycosis. West J Med 1993; 158:300-301
3. Ragland AS, Arsura EL, Ismail Y, Johnson R: Eosinophilic pleocytosis in coccidioidal meningitis: Frequency and significance. Am J Med 1993; 95:254-257

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## Dr Fuller Responds

TO THE EDITOR: I thank Drs Ismail and Arsura for bringing to my attention coccidioidal meningitis as a cause of eosinophilic meningitis. I read their recent article with interest.<sup>1</sup>

*Coccidioides immitis* is not found in Australia or the Pacific region, but most certainly should be considered in California as the most likely cause of eosinophilic meningitis.

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## REFERENCE

1. Ismail Y, Arsura EL: Eosinophilic meningitis associated with coccidioidomycosis. West J Med 1993; 158:300-301

## Posthypnotic Suggestion

TO THE EDITOR: I read with fascination the article, "Effect of Preoperative Suggestion on Postoperative Gastrointestinal Motility," by Disbrow and colleagues in the May 1993 issue.<sup>1</sup> It is a little disconcerting that the effort was not properly labeled as the effects of "posthypnotic suggestion" because that is certainly what took place. When a person's mind is concentrated—as it would be in a surgical setting—and he or she is given a suggestion that is accepted, that is called hypnosis.

I am bothered by the confusion in the article and in the editorial by Witte and Witte<sup>2</sup> over conscious versus subconscious thoughts that influenced the results. It was the subconscious acceptance of the suggestions and not conscious thoughts that provided the positive results. Hypnotic suggestions work only through subconscious control. After all, in the article on suggestions under anesthesia referred to by Witte and Witte,<sup>3</sup> the patients could not have had a conscious thought because they were unconscious.

Also, concerning the preoccupation with the Stanford Clinical Hypnosis Scale scores, everyone is suggestible to some degree through hypnosis. After all, who has not had the experience of driving on the freeway and suddenly becoming aware that they had driven 20 miles without realizing it? Their mind was superconcentrated in a hypnotic trance, and when they woke up, they had amnesia for the distance traveled.

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## REFERENCES

1. Disbrow EA, Bennett HL, Owings JT: Effect of preoperative suggestion on postoperative gastrointestinal motility. West J Med 1993; 158:488-492
2. Witte CL, Witte MH: Ileus and ignorance (Editorial). West J Med 1993; 158:532-534
3. McLintock TT, Aitken H, Downie CFA, Kenny GNC: Postoperative analgesic requirements in patients exposed to positive intraoperative suggestions. BMJ 1990; 301:788-790

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## Drs Disbrow, Bennett, and Owings Respond

TO THE EDITOR: As Dr Tayloe has ascertained, the intervention used in our article could be called a posthypnotic suggestion. We feel this distinction is unnecessary, however. Whether patients are in a hypnotic state or not, the results of our study are the same. We did not use the term hypnosis because we did not induce a special state of consciousness. Instead, we incorporated the essential aspects of hypnosis that make it effective for altering physiologic functioning and that were already present in the hospital environment.

The intervention was based largely on the writings of Barber, who defined hypnosis as "a situation in which individuals are purposefully guided by carefully chosen words and communications (suggestions) to 'let go' of ex-

traneous concerns and to feel-think-imagine-experience ideas or events that they are rarely asked to experience."<sup>1(p69)</sup> Hypnosis is not described as a mysterious alternate state of consciousness. Instead, it is a situation in which the subject has a high expectancy or belief in the intervention, is highly motivated, and is focused on the intervention and free of distractions.

These criteria are routinely met in the preoperative hospital environment. Researchers or physicians are looked on by patients as authorities or experts, thus lending credibility to the intervention and instilling an expectancy of success in the patients. Because undergoing a surgical procedure is usually an emotional and physical crisis, patients are highly motivated to recover. An intervention taking place shortly before the procedure is likely to hold the interest and focus the attention of a patient. If properly administered, suggestions given by the physician shortly before an operation can produce positive results by mimicking the essential characteristics of hypnosis.

Because everyone is suggestible to some degree, we attempted to quantify—using the Stanford Hypnosis Clinical Scale—the influence of susceptibility to suggestion on the resolution of ileus. The Stanford Hypnosis Clinical Scale scores were not significantly correlated with the resolution of ileus, and there was no interaction between these scores and the experimental condition. Therefore, all patients can benefit from direct physiologic suggestions regardless of their susceptibility to suggestion.

In short, all patients seen by a physician in a preoperative setting are in a “hypnotic” state. The physician may choose to take advantage of this state and provide specific physiologic suggestions that patients can incorporate to hasten their recovery. Our study shows that patients will respond with a reduction in the duration of ileus.

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#### REFERENCE

1. Barber TX: Changing ‘unchangeable’ bodily processes by (hypnotic) suggestions: A new look at hypnosis, cognitions, imaging, and the mind-body problem, *In* Sheikh AA (Ed): *Imagination and Healing*. New York, NY, Baywood Publishing, 1984, pp 69-127

## AIDS in India

TO THE EDITOR: Deborah Porterfield's personal reflections in the May 1993 issue<sup>1</sup> are certainly an eye opener to the policymakers of industrialized nations emphasizing the urgent need for redefining their global policy on the acquired immunodeficiency syndrome (AIDS). This article, however, puts physicians in developing nations in a bad light, depicting them as disinterested, misinformed, and apathetic. Having been associated with sexually transmitted diseases clinics in the Indian subcontinent, we think that such generalizations can be unfair to the scores

of dedicated physicians in developing nations who deal with AIDS patients in the setting of scarce resources, with practically no backing at all from the international community. Given the cultural and ethnic diversity, socioeconomic impediments, and widespread illiteracy in these areas, the challenges faced by these physicians are at times insurmountable, which can be frustrating.

In a country like India where the population tops 1 billion, one needs to realize that the recent international funding of around \$84 million<sup>2</sup> over a five-year period is too miniscule an amount even to initiate any worthwhile efforts to combat the epidemic. In fact, international financial support for AIDS prevention actually declined in the past year to around \$110 million, roughly equivalent to a seventh of the public expenditure on AIDS in the United States.<sup>3</sup> Also, only 6% of global funding for the prevention of the human immunodeficiency virus (HIV) was spent in countries with 80% of the world's HIV-infected population.<sup>3</sup> Hence, we may assume that the faltering response from developed nations to assist global efforts against this epidemic has directly or indirectly resulted in the explosion of AIDS in developing nations like India. Physicians reading Porterfield's article may be misled into viewing the impact in the United States as minor compared with the global “time bomb” elsewhere. But one needs to realize that institutions in the United States are strong while the overall number of HIV-infected people in the US population is relatively small, around 0.4%.<sup>3</sup> Thus, creating a major distinction between countries can be unfair, and one primarily needs to blame this grossly inadequate global response for the current explosion of AIDS in heavily populated countries such as India, China, and Pakistan, which stand on the verge of national epidemics.

As rightly pointed out by Mann and colleagues: “A global ethic of caring has not been developed, and the global vision is dimming as HIV/AIDS is depicted as a ‘developing country’ problem. As a result, global leadership is declining.”<sup>3</sup> It is time that all “world citizens” accept that AIDS is “our disease, not yours” and that industrialized nations like the United States take leadership roles in combating this common enemy, rather than making distinctions. Visitors like Porterfield need to perceive this aspect in their views about AIDS in developing nations.

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#### REFERENCES

1. Porterfield DS: Human immunodeficiency virus in India—Reflections of a visitor. *West J Med* 1993; 158:527-529
2. Ramalingaswami V: India: National plan for AIDS control (News). *Lancet* 1992; 339:1162-1163
3. Worldwide denial, complacency are hindering war against AIDS epidemic. *AIDS Alert Supplement* April 1993 [American Health Consultants Inc, 3525 Piedmont Rd, Bldg 6, Ste 400, Atlanta, GA 30305]